The Essential Health Benefits Package

The Affordable Care Act (ACA) requires many health care plans – specifically, those provided by Medicaid and insurers in the individual and small group markets – to provide "essential health benefits" (Sec. 1302), whose meaning is therefore a key element to all of PPACA.

The law explicitly includes "mental health and substance use disorder services, including behavioral health treatment"[1] in the list of essential health benefits that Medicaid, individual, and small group plans must provide. This is true of individual and small group plans regardless of whether they're offered within or outside the exchange. The "essential health benefit" plans do not apply to large group plans, unless after 2017 the state health insurance exchange is made available to larger employers with 100 or more employees.

The Affordable Care Act defines essential health benefits to 'include at least the following general categories and the items and services covered within the categories:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care

According to the Department of Health and Human Services, "Starting with plan years or policy years that began on or after September 23, 2010, health plans can no longer impose a lifetime dollar limit on spending for these services. All plans, except grandfathered individual health insurance policies, must phase out annual dollar spending limits for these services by 2014."[2]

The rules establishing "essential health benefits" will be open to public comment.

[1] PPACA Sec. 1302
[2] "Essential Health Benefits." Healthcare.gov Glossary. <http://www.healthcare.gov/glossary/e/essential.html>

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